

Patient-Centered Care Transitions

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Background

- Hospitalizations represent a vulnerable time in the health of a patient
 - ~20% of CMS beneficiaries were readmitted within 30 days, raising concerns of poor or inadequate care
- Numerous studies show multi-dimensional, hospital-based approaches may help improve care transitions
- The patient-centered primary care home is an optimal location to center outpatient-based improved care transition efforts

Project Aim

Develop a sustainable model for outpatient-initiated patient-centered care transitions

Objectives:

- Implement a standard model for transitional care management at OHSU primary care clinics
- Improve patient safety during transitions from hospital care to community-based care
- Improve the patient experience during transitions from hospital care to community-based care

Project Team

OHSU Family Medicine

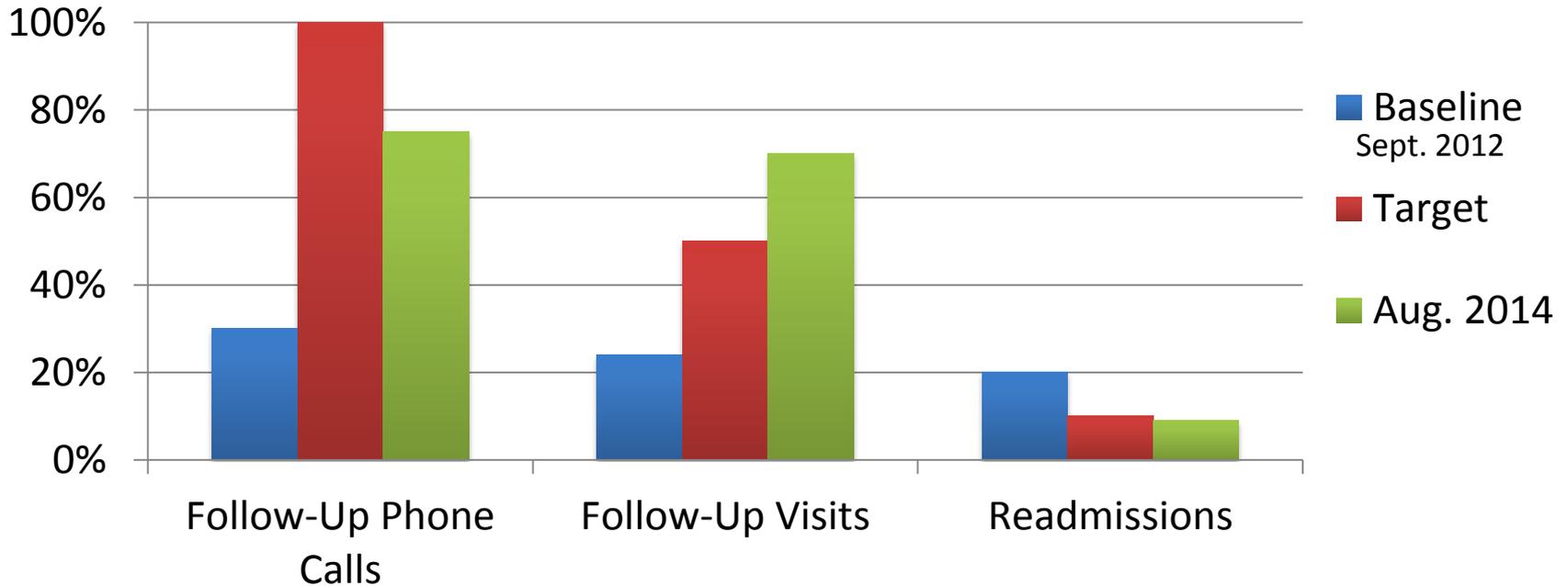
Jessie Flynn, MD - medical director, Family Medicine
Inpatient Service

- OHSU Family Medicine Clinic leadership
 - South Waterfront, Gabriel Park, Richmond and Scappoose
- Patient access specialists
 - Annie Wood
 - Natalie Gutzler
 - Keatra Patton
- Team RN
 - Jan Call, RN

Project Measures

- Post-discharge follow-up phone calls
 - Baseline: not happening
 - Target: 90%
- Post-discharge follow-up visits (within 7 days of discharge)
 - Baseline: 30%
 - Target: 50%
- Readmission rates
 - Baseline: 20%
 - Target: 10%
- Future measures:
 - Transitional care visits billed
 - Patient satisfaction HCAHPS scores (Hospital Consumer Assessment of Healthcare Providers and Systems)

Progress to Date and Next Steps



Next steps:

- Reach out to non-OHSU clinics
- Patient satisfaction measures